

		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0035006</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>St Patrick's Residence</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2003</u> to <u>12/31/2003</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>1400 Brookdale Road</u> <u>Naperville</u> <u>60563</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Dupage</u>			
Telephone Number: <u>630 416-6565</u> Fax # <u>630 416-1364</u>			
IDPA ID Number: <u>36-2527011 001</u>			
Date of Initial License for Current Owners: <u>03/07/1965</u>			
Type of Ownership:			
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT			
<input checked="" type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
IRS Exemption Code _____			
<input type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Robert A. Gancarz</u> Telephone Number: <u>630 416-6565 X502</u>		(Signed) _____ <u>04/28/2004</u> (Date) (Type or Print Name) <u>Sister Jeanne Francis Haley</u> (Title) <u>Administrator</u> (Signed) _____ (Date) (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____	
		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

STATE OF ILLINOIS

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Facility Name & ID Number St Patrick's Residence# 0035006 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>42</u>	Skilled (SNF)	<u>42</u>	<u>15,330</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>146</u>	Intermediate (ICF)	<u>156</u>	<u>55,540</u>	3
4		Intermediate/DD			4
5	<u>22</u>	Sheltered Care (SC)	<u>12</u>	<u>5,780</u>	5
6		ICF/DD 16 or Less			6
7	<u>210</u>	TOTALS	<u>210</u>	<u>76,650</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>632</u>	<u>10,840</u>	<u>3,532</u>	<u>15,004</u>	8
9	SNF/PED					9
10	ICF	<u>39,584</u>	<u>14,926</u>		<u>54,510</u>	10
11	ICF/DD					11
12	SC	<u>2,211</u>	<u>3,442</u>		<u>5,653</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>42,427</u>	<u>29,208</u>	<u>3,532</u>	<u>75,167</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 98.07%

D. How many bed-hold days during this year were paid by Public Aid?

225 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 05/22/1989

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 05/22/1989 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 42 and days of care provided 3,532Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/2003 Fiscal Year: 12/2003

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

St Patrick's Residence

0035006

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	631,009	64,567	46,139	741,715		741,715	(29,932)	711,783			1
2	Food Purchase		421,407		421,407		421,407	(7,256)	414,151			2
3	Housekeeping	423,866	60,996		484,862		484,862	(21,755)	463,107			3
4	Laundry	198,034	21,013	1,421	220,468		220,468	(11,922)	208,546			4
5	Heat and Other Utilities			203,265	203,265		203,265	(1,512)	201,753			5
6	Maintenance	226,951	24,181	33,928	285,060		285,060	19,805	304,865			6
7	Other (specify):*											7
8	TOTAL General Services	1,479,860	592,164	284,753	2,356,777		2,356,777	(52,572)	2,304,205			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	3,646,850	225,624	1,557,202	5,429,676		5,429,676		5,429,676			10
10a	Therapy	133,322	3,564		136,886		136,886		136,886			10a
11	Activities	138,301	3,675	2,069	144,045		144,045		144,045			11
12	Social Services	184,483			184,483		184,483		184,483			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,102,956	232,863	1,577,271	5,913,090		5,913,090		5,913,090			16
	C. General Administration											
17	Administrative	253,944		41,233	295,177		295,177		295,177			17
18	Directors Fees											18
19	Professional Services			72,785	72,785		72,785		72,785			19
20	Dues, Fees, Subscriptions & Promotions			68,284	68,284		68,284	(2,463)	65,821			20
21	Clerical & General Office Expenses	234,154	28,763	83,373	346,290		346,290	(41,481)	304,809			21
22	Employee Benefits & Payroll Taxes			1,054,894	1,054,894		1,054,894	(14,624)	1,040,270			22
23	Inservice Training & Education			2,374	2,374		2,374		2,374			23
24	Travel and Seminar			2,548	2,548		2,548	(1,673)	875			24
25	Other Admin. Staff Transportation			3,279	3,279		3,279		3,279			25
26	Insurance-Prop.Liab.Malpractice			200,962	200,962		200,962	(12,076)	188,886			26
27	Other (specify):* HIPAA Officer	19,412			19,412		19,412		19,412			27
28	TOTAL General Administration	507,510	28,763	1,529,732	2,066,005		2,066,005	(72,317)	1,993,688			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,090,326	853,790	3,391,756	10,335,872		10,335,872	(124,889)	10,210,983			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			575,922	575,922		575,922		575,922			30
31	Amortization of Pre-Op. & Org.			7,667	7,667		7,667		7,667			31
32	Interest			258,997	258,997		258,997	(93,028)	165,969			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			842,586	842,586		842,586	(93,028)	749,558			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		390,780	431,498	822,278		822,278		822,278			39
40	Barber and Beauty Shops	50,009	1,086		51,095		51,095	(62,099)	(11,004)			40
41	Coffee and Gift Shops		2,808		2,808		2,808	(36,968)	(34,160)			41
42	Provider Participation Fee			106,710	106,710		106,710		106,710			42
43	Other (specify):*	61,025		73,713	134,738		134,738	(134,738)				43
44	TOTAL Special Cost Centers	111,034	394,674	611,921	1,117,629		1,117,629	(233,805)	883,824			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,201,360	1,248,464	4,846,263	12,296,087		12,296,087	(451,722)	11,844,365			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

	1	2	3	
	Amount	Refer- ence	OHF USE ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income	(93,028)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(20,842)	21		24
25 Fund Raising, Advertising and Promotional				25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule				29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (113,870)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)			34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (113,870)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.			\$		38
39					39
40 Gift and Coffee Shops					40
41 Barber and Beauty Shops					41
42 Laboratory and Radiology					42
43 Prescription Drugs					43
44 Exceptional Care Program					44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

St Patrick's Residence

ID# 0035006

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Investment Expense	\$ (17,184)	21	1
2	Development Salary	(61,025)	43	2
3	Development Expense	(42,704)	43	3
4	Fund Raising Expenses	(30,624)	43	4
5	Barber & Beauty Income	(62,099)	40	5
6	Coffee & Vending Income	(36,968)	41	6
7	Stamp Income	(1,108)	21	7
8	Happy Hour Expense	(2,347)	21	8
9	Public Relations	(385)	43	9
10	Undocumented Travel & Seminar Expense	(1,673)	24	10
11	Promotional Advertising	(2,463)	20	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(258,580)		49

Summary A

12/31/2003

[illegible]

Summary B

12/31/2003

[illegible]

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Carmelite Sisters	100.00			Carmelite System	Germantown, NY	Religious Order

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	1 Dietary	\$ 29,932	Carmelite Sisters of the Aged and Infirm		\$	(29,932) 1
2	V	2 Food Purchase	27,462	Carmelite Sisters of the Aged and Infirm		20,206	(7,256) 2
3	V	3 Housekeeping	21,755	Carmelite Sisters of the Aged and Infirm			(21,755) 3
4	V	4 Laundry	11,922	Carmelite Sisters of the Aged and Infirm			(11,922) 4
5	V	5 Utilities	18,394	Carmelite Sisters of the Aged and Infirm		16,882	(1,512) 5
6	V	6 Maintenance	25,753	Carmelite Sisters of the Aged and Infirm		45,558	19,805 6
7	V	22 Employee Benefits	14,624	Carmelite Sisters of the Aged and Infirm			(14,624) 7
8	V	26 Insurance	12,076	Carmelite Sisters of the Aged and Infirm			(12,076) 8
9	V						9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ 161,918			\$ 82,646	\$ * (79,272) 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St Patrick's Residence# 0035006 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (____) _____

Fax Number (____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number St Patrick's Residence# 0035006

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Interest Expense	10
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	City of Naperville-Usbank		X	Mortgage		12/19/98	\$ 6,820,000	\$ 5,065,000	01/01/2013	0.0491	\$ 252,545	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Harris Bank		X	Working Capital		03/19/03	240,000		05/01/2004	0.0400	6,452	6
7												7
8												8
9	TOTAL Facility Related						\$ 7,060,000	\$ 5,065,000			\$ 258,997	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 7,060,000	\$ 5,065,000			\$ 258,997	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																												
1. Real Estate Tax accrual used on 2002 report.	\$		1																									
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$		2																									
3. Under or (over) accrual (line 2 minus line 1).	\$		3																									
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	\$		4																									
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5																									
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.																												
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6																									
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$		7																									
Real Estate Tax History:																												
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1998</td><td>8</td></tr> <tr><td>1999</td><td>9</td></tr> <tr><td>2000</td><td>10</td></tr> <tr><td>2001</td><td>11</td></tr> <tr><td>2002</td><td>12</td></tr> </table>	1998	8	1999	9	2000	10	2001	11	2002	12	<table border="1"> <tr> <td></td> <td>FOR OHF USE ONLY</td> <td></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2002 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>			FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2002 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
1998	8																											
1999	9																											
2000	10																											
2001	11																											
2002	12																											
	FOR OHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2002 \$	13																										
14	PLUS APPEAL COST FROM LINE 5 \$	14																										
15	LESS REFUND FROM LINE 6 \$	15																										
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																										

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Patrick's Residence COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0035006

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 118,218

B. General Construction Type: Exterior CMV Block & Brick Frame Pre-Cast Concrete

Number of Stories Three

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☒ YES
 ☐ NO

If so, please complete the following:

1. Total Amount Incurred: 116,922

2. Number of Years Over Which it is Being Amortized: 15

3. Current Period Amortization: 7,667

4. Dates Incurred: 1997

Nature of Costs: Bond Issuance Costs

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	7.33 Acres	1987	\$ 638,590	1
2					2
3	TOTALS	7		\$ 638,590	3

STATE OF ILLINOIS

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Facility Name & ID Number St Patrick's Residence

0035006

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	210	1989	1989	\$ 7,786,645	\$ 275,943	25-40	\$ 275,943		\$ 4,032,315
5		1997	1997	2,194,676	54,867	40	54,867		356,635
6		2000	2000	2,987,034	74,675	40	74,675		201,802
7									
8									
Improvement Type**									
9	Land Improvements-Bushes/Shrub	1990		10,000		10			10,000
10	Land Improvements-Asphalt Paving	1990		118,000	7,867	15	7,867		115,380
11	Land Improvements-Asphalt Paving	1993		13,251		5			13,251
12	Land Improvements-Trees	1993		9,351	307	10	307		9,351
13	Land Improvements-Flag Pole	1994		1,501	75	20	75		717
14	Land Improvements-Trees and Bushes	1997		40,600	2,030	20	2,030		13,195
15	Land Improvements-Trees	1998		3,022	151	20	151		831
16	Land Improvements-Aphalt paving	2000		6,838	342	20	342		1,197
17	Building Improvement-Awning	1991		4,862	324	15	324		4,213
18	Building Improvement-Doors	1993		6,175	537	10	537		6,175
19	Building Improvement-Window	1994		2,172	144	15	144		1,456
20	Building Improvement-Closets	1994		15,306	1,020	15	1,020		9,701
21	Building Improvement-Main Dining Room	1994		13,345	996	15	996		12,432
22	Building Improvement-Beauty Shop	1996		2,417	242	10	242		1,873
23	Building Improvement-Business Office	1996		559		5			559
24	Building Improvement-Smoke Alarm	1997		9,000		10			9,000
25	Building Improvement-Business Office	1997		1,966		10			1,966
26	Building Improvement-Building Plaque	1997		1,000		10			1,000
27	Building Improvement-Stained Glass	1998		14,500	363	40	363		1,994
28	Building Improvement-Magnetic Doors	1998		4,949	495	10	495		2,722
29	Building Improvement-Mortar Repair	1998		5,744	574	10	574		3,159
30	Building Improvement-Outside Sign	1999		3,200	320	10	320		1,440
31	Building Improvement-Security System	1999		3,632	363	10	363		1,634
32	Building Improvement-Outside Awning	2000		2,398	120	20	120		420
33	Building Improvement-Expansion Join	2000		7,345	367	20	367		1,285
34	Building Improvement-Cooling Pump	2001		10,440	522	20	522		1,305
35	Building Improvement-Fire Sprinkler main	2002		3,966	198	10	198		396
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 13,283,894	\$ 422,842		\$ 422,842	\$	\$ 4,817,404	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number St Patrick's Residence

0035006

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,306,833	\$ 129,676	\$ 129,676	\$		\$ 1,862,977	71
72	Current Year Purchases	141,954	12,843	12,843		5 & 10	12,843	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,448,787	\$ 142,519	\$ 142,519	\$		\$ 1,875,820	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Business	1994 Ford Bus	1994	\$ 39,951	\$ 3,995	\$ 3,995	\$	10	\$ 39,656	76
77	Facility Business	1996 Dodge Pickup	2000	23,116	4,623	4,623		5	16,189	77
78	Facility Business	1999 Pontiac Grand Am	2002	9,717	1,943	1,943		5	2,907	78
79										79
80	TOTALS			\$ 72,784	\$ 10,561	\$ 10,561	\$		\$ 58,752	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 16,444,055	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 575,922	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 575,922	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,751,976	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Architectural Costs	\$ 101,889	92
93			93
94			94
95		\$ 101,889	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2004 \$ _____

13. _____/2005 \$ _____

14. _____/2006 \$ _____

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO </div> <p style="font-size: small;">If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 82,442	\$		\$ 82,442	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			12,487			12,487	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			87,449			87,449	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				359,845		359,845	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Schedule					249,120	30,935		280,055	13
14	TOTAL			\$		\$ 431,498	\$ 390,780		\$ 822,278	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

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Facility Name & ID Number St Patrick's Residence

0035006

Report Period Beginning: 01/01/2003

Ending:

12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,993,836	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 66,284)	1,013,412		3
4	Supply Inventory (priced at Cost)	35,937		4
5	Short-Term Investments	1,820,135		5
6	Prepaid Insurance	334,412		6
7	Other Prepaid Expenses	25,520		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,223,252	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	638,590		13
14	Buildings, at Historical Cost	13,081,268		14
15	Leasehold Improvements, at Historical Cost	202,563		15
16	Equipment, at Historical Cost	2,521,571		16
17	Accumulated Depreciation (book methods)	(6,751,973)		17
18	Deferred Charges	101,889		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	70,000		21
22	Other Long-Term Assets (specify) <u>Pledge Receivable</u>	1,860,000		22
23	Other(specify): <u>Bond Issuance Costs</u>	70,340		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,794,248	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 17,017,500	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 742,897	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	487,545		30
31	Accrued Taxes Payable (excluding real estate taxes)	28,906		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	127,109		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	20,508		36
37	<u>Medicare Settlement</u>	25,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,431,965	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,065,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Capital Lease</u>	17,847		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,082,847	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,514,812	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 10,502,688	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 17,017,500	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,262,048	1
2	Restatements (describe):		2
3	Compensated Absences Adjustment	(33,728)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,228,320	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	60,960	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	213,408	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 274,368	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 10,502,688	24

*

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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Facility Name & ID Number St Patrick's Residence

0035006

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 14,381,676	1
2	Discounts and Allowances for all Levels	(4,051,180)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,330,496	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	950,672	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 950,672	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	36,968	12
13	Barber and Beauty Care	62,099	13
14	Non-Patient Meals	20,206	14
15	Telephone, Television and Radio	25,798	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,235	19
20	Radiology and X-Ray	26,973	20
21	Other Medical Services	137,681	21
22	Laundry	3,568	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 319,528	23
	D. Non-Operating Revenue		
24	Contributions	243,190	24
25	Interest and Other Investment Income***	93,028	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 336,218	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Gain On Investments	357,693	28
28a	Facility Revenue	62,440	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 420,133	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,357,047	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,356,777	31
32	Health Care	5,913,090	32
33	General Administration	2,066,005	33
	B. Capital Expense		
34	Ownership	842,586	34
	C. Ancillary Expense		
35	Special Cost Centers	1,010,919	35
36	Provider Participation Fee	106,710	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,296,087	40
41	Income before Income Taxes (line 30 minus line 40)**	60,960	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 60,960	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **St Patrick's Residence**# **0035006**Report Period Beginning: **01/01/2003**

Ending:

12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,334	2,631	\$ 60,099	\$ 22.84	1
2	Assistant Director of Nursing	1,883	2,323	53,092	22.85	2
3	Registered Nurses	37,287	39,996	1,067,266	26.68	3
4	Licensed Practical Nurses	18,413	19,924	398,326	19.99	4
5	Nurse Aides & Orderlies	126,028	139,548	2,068,067	14.82	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,011	2,275	54,359	23.89	7
8	Rehab/Therapy Aides	3,802	4,262	78,963	18.53	8
9	Activity Director	2,204	2,364	26,586	11.25	9
10	Activity Assistants	6,733	7,694	111,715	14.52	10
11	Social Service Workers	10,627	11,891	184,483	15.51	11
12	Dietician	1,960	2,160	50,638	23.44	12
13	Food Service Supervisor	5,433	6,298	88,839	14.11	13
14	Head Cook	5,693	6,703	99,855	14.90	14
15	Cook Helpers/Assistants	39,770	43,014	350,653	8.15	15
16	Dishwashers	4,437	4,943	41,024	8.30	16
17	Maintenance Workers	17,364	18,669	226,951	12.16	17
18	Housekeepers	44,782	48,130	423,866	8.81	18
19	Laundry	19,756	22,037	198,034	8.99	19
20	Administrator	2,160	2,320	66,317	28.58	20
21	Assistant Administrator	2,160	2,320	60,382	26.03	21
22	Other Administrative	1,964	2,170	57,095	26.31	22
23	Office Manager	2,124	2,432	70,150	28.84	23
24	Clerical	13,688	15,400	234,154	15.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,141	1,221	19,412	15.90	31
32	Other Health Care(specify)					32
33	Other(specify) Dvlpmnt/Beauty	5,900	6,345	111,034	17.50	33
34	TOTAL (lines 1 - 33)	379,654	417,070	\$ 6,201,360 *	\$ 14.87	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	18,000	9-3	36
37	Medical Records Consultant	88	4,103	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,320	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	37	2,069	10-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	125	\$ 25,492		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	19,621	\$ 804,454	10-3	50
51	Licensed Practical Nurses	4,162	158,146	10-3	51
52	Nurse Aides	28,740	589,180	10-3	52
53	TOTAL (lines 50 - 52)	52,523	\$ 1,551,780		53

Facility Name & ID Number	St Patrick's Residence
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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership %	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function		Amount		Description	Amount	Description	Amount	
Sister Jeanne	Administrator		\$ 66,317		Workers' Compensation Insurance	\$ 86,000	IDPH License Fee	\$	
Sister Ann	Asst Adminstrtrr		60,382		Unemployment Compensation Insurance	25,895	Advertising: Employee Recruitment	49,470	
Robert Gancarz	Controller		70,150		FICA Taxes	451,274	Health Care Worker Background Check (Indicate # of checks performed 245)	1,715	
Ken Deardorff	HR Director		57,095		Employee Health Insurance	305,300			
					Employee Meals		Association Fees	9,439	
					Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	5,197	
					Life and Disability Insurance	39,237	Promotional Advertising	2,463	
					Pension	90,707			
					Staff Development	5,850			
					Employee Physicals & vaccinations	6,004			
					Bank Time Expense	44,627			

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network \$9,439
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 114,440 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 106,710
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Frost, Ruttenberg & Rothblatt The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Cost Center Expenses (Schedule V.)
Other Expense-Line 43

Column	Description	Amount	Total
1	Development Salary	\$ 61,025	<u><u>\$ 61,025</u></u>
3	Development Expense	\$ 42,704	
3	Fund Raising Expense	30,624	
3	Public Relations	385	
			<u><u>\$ 73,713</u></u>

Board of Directors Listing

Bishop Joseph L. Imesch

Reverend Joel Fortier

Sister Ann Elizabeth Brown, O.Carm.

Sister M. Teresa Stephen Pereira, O.Carm.

Sister M. Kevin Patricia Lynch, O.Carm

Sister M. Paul Anthony Videtich, O.Carm

Sister Norah Michael McNamara, O.Carm

Sister Mary Rose Heery, O.Carm

Mr. John J. Durso

Mrs. Nancy L. Gorman

Mr. Carmen S. DiGiovine

Mr. Raymond E. Jones

Miss Josephine Mancuso

Mr. Frank G. Slocumb

Facility Name & ID Number Saint Patrick's Residence

STATE OF ILLINOIS
0035006

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Report Period Begin: 1/1/2003 Ending: #####

Special Services(Schedule XIV.)

Supplemental Schedule of Medical Supplies
Line 13

<u>Supplies (column 6)</u>	<u>\$ Amount</u>
1-X-Ray Services	\$ 21,035
2-EKG Services	<u>9,900</u>
Total 39-3	<u><u>\$ 30,935</u></u>

<u>Outside Practitioner (column 5)</u>	<u>\$ Amount</u>
1-Medicare Part A Therapies	<u>\$ 249,120</u>
Total 39-2	<u><u>\$ 249,120</u></u>